Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	Rx _____ Physician signature _____ Date

This includes all generic equivalents

DRUGS for ALLERGIES - Non-Sedating Antihistamines			
Preferred Drug Covered		Non-preferred Prior Authorization Required	
Cetirizine all dosage forms	Zyrtec® Zyrtec Syrup®	Desloratadine all dosage forms	Clarinex®
Cetirizine / Pseudoephedrine	Zyrtec-D® **KBH only**	Desloratadine/ Pseudoephedrine	Clarinex-D 12-hour® Clarinex-D 24-hour® **KBH only**
Loratadine all dosage forms	Claritin® Claritin 24-hr Allergy® Claritin Hives Relief® Claritin RediTabs® Claritin® Syrup	Fexofenadine all dosage forms	Allegra®
Loratadine/ Pseudoephedrine	Claritin-D12® **KBH only** Claritin-D24® **KBH only**	Fexofenadine / Pseudoephedrine	Allegra-D® **KBH only** Allegra-D24® **KBH only**

**** Indicates REQUIRED information**

****CONSUMER NAME:** _____ ******Medicaid Number:_____

****PHARMACY NAME:**_____ ******Medicaid Number:_____

******Phone Number:_____ ******Fax Number:_____ ******NDC:_____

****PRESCRIBING PHYSICIAN NAME:**_____ ******Medicaid Number:_____

******Phone Number:_____ ******Fax Number:_____

****** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

****** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

****** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

******Prescribing Physician's signature: _____Date: _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

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